pelvic recurrence 10.5%(n=2), no distant metastasis. Final histology 17% upstaged, 61% down-staged and 22% unchanged. Day time urinary incontinence 0%, Nocturnal incontinence 27.7%, continent 72.3%, failure to void and Intermittent self catheterisation 27.7%. Average neo-bladder capacity 700-1400mls.
Conclusion: Downward trend noted in ONB reconstruction. Postop blood transfusion none ;hospital stay 10 days. Higher self-catheterisation (CISC) rate in male patients, urinary continence and complications rate are equally comparable to other published series.

0795: TRIAL WITHOUT CATHETER; ARE WE FAILING OUR PATIENTS?

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Aim: Acute urinary retention (AUR) is the most common urological emergency with an incidence of approximately 3/1,000 men per annum in England. Long waiting time for appointment to trial without catheter (TWOC) clinics causing wide range of complications affecting patient's quality of life and burdened the NHS. This study was conducted to evaluate TWOC clinic services across the UK.
Methods: Data collected through validated questionnaire uploaded to senior urology registrar group(SURG) website, via controlled access to a national list of www.nhs.net e-mail addresses of health professionals, telephonic feedback and direct contact in urology meetings.
Results: TWOC available in 100% district hospitals. Urology nurse practitioners(89.4%) doctors(5.3%) and healthcare assistants(5.3%) conducts the clinics. 47% clinics scheduled twice per week. Average appointment time is 7-14days(55%). Prior to TWOC selective alpha-blocker prescribed in 92%. Appointments booked through Urologist are 42%,(GP)10% and (A&E)40%. 71% patients spent 2-4 hrs and 13% spent>4hrs in TWOC clinics. 55.5% clinics record flow rate and residual urine. Only 26% departments do regularaudits. 76% responders are satisfied from TWOC services others not because of long waiting time.
Conclusion: The results high-lightened the risk associated aspects of the care provision. It also raises the concerns about the quality of service and areas of potential improvement.

0802: ROLE OF IMAGING IN FOLLOW-UP AFTER RADICAL CYSTECTOMY

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Aim: We aim to devise an evidence-based up-to-date schedule for follow-up imaging post-cystectomy for muscle-invasive bladder cancer: stratified according to risk factors, recurrence timings, and relative survival benefits of early asymptomatic detection.
Methods: Medline and relevant EAU and AUA guidelines reference lists were searched to identify appropriate papers for inclusion.
Results: CT and chest X-ray are best for detecting local and distant metastases; MRI is a sensitive, non-ionising alternative. Trans-rectal ultrasonography may be effective in local recurrence detection.
80-90% of recurrences occur within three years: high stage and grade of the primary tumour, and positive invasion status at cystectomy increase risk. Local (pelvic) and distant (bone, liver and lung) metastases are more likely to recur within the first year, especially in high-risk groups. Early detection is associated with longer survival times. After three years, urothelial tumours are more likely to recur; however, there are no significant survival benefits to routine imaging.
Conclusion: We propose three strata of patients: high risk (high grade/stage), intermediate, or low. In the first three years: high-risk patients should be imaged 6-monthly; low-risk, annually; and patients with intermediate-risk, 6-monthly in the first year, then annually. After three years, imaging should be guided based on symptoms.

0804: ARE WE REQUESTING BONE SCANS APPROPRIATELY?

M. Pereira*, I. Ward, M.I. Johnson. *Freeman Hospital, UK*

Aim: To correlate the results of prostate cancer patient's bone scans (BS) with their PSA and pathology findings.
Methods: A retrospective study of all BS performed between April and June at our hospital, in patients known to have prostate cancer. The following data was collected: age, BS reports, latest PSA, Gleason score and further imaging.
Results: During this period, 247 BS were performed. From these 167 BS were performed for patients with prostate cancer. There were 141 patients that were not known to have bone metastasis. In this group 19% had PSA <10, and 26% had PSA 10-20. 19% of these BS were equivocal and required further imaging, but after additional imaging were negative.
Overall no patient with PSA <20 had bone metastasis confirmed, and also 25% of BS were positive – all of which had PSA >20. The likelihood for the patient to have metastatic bone disease with PSA <20 is very low. The finding of equivocal scans requires further imaging, which adds cost for the NHS and stress for the patient.
Conclusion: The PSA value is a valuable tool for prediction of positive bone scan, and it can be used to rationalise requesting bone scan and avoid patient distress.

0838: ROLE OF PATHOLOGICAL EXAMINATION OF VAS DEFERENS IN VASECTOMY

P. Cleaveland*, A. Doyle, M. Badat, B. Zelhof. *Lancashire Teaching Hospitals Trust, UK*

Aim: Vasectomy is the most reliable form of male contraception. Current practice at Royal Preston Hospital is to send the vas for pathological examination to confirm its excision. The European Association of Urology and Royal College of Reproductive Medicine Guidelines state that there is no need for routine pathologic examination of the vas. Success of the procedure is confirmed by semen analysis at 12 weeks.
Methods: All males who underwent vasectomy in the trust from January to December 2013 were included in the audit. Case notes and electronic records were reviewed. Parameters including demographics, surgical technique, histology, semen analysis and complications were recorded.
Results: 61 vasectomies were performed. Mean age was 39.5. 70.5% were done under local anaesthetic. Vas histology was performed in 85.2% with only 3.3% showing incomplete excision. 2 patients underwent re-do vasectomy due to positive semen analysis. One of these had normal vas histology and the other the vas wasn't found.
Conclusion: Pathological examination of the vas deferens does not contribute to determining whether a vasectomy has been successful. Semen analysis is the optimal test. We recommend that pathological examination of the vas is no longer performed in our trust which will save costs and resources.

0895: OUTCOMES OF AUGMENTATION CYSTOPLASTY

S. Husain*, J. Bechar, M. Belal. *University Hospitals Birmingham NHS Foundation Trust, UK*

Aim: To review postoperative complications for Augmentation Cystoplasty procedures carried out in the Trust and to evaluate the quality of life (QoL) of these patients post procedure.
Methods: A retrospective case note review for procedures in the last 3 years (August 2011 to 2014). Data on basic patient demographics, indication for surgery, procedure performed and post-operative complications evaluated against Clavien-Dindo Classification and documented. QoL assessed using validated measures: EQ-5D-5L Health questionnaire and ICIQ-UI Incontinence questionnaire.
Results: In total, 15 patients were identified in the last 3 years. Indication for surgery: 7 congenital and 8 acquired causes. 8 cases had additional Mitrofanoff procedure. Overall, 8 cases had Clavien 1 complications, 5 cases had Clavien 2 complications and 2 cases had Clavien 3b complications. EQ-5D-5L Health questionnaire conducted found an average Mobility score 2.625, Self-care score 1.875, Usual activity score 1.875, Pain/discomfort score 1.875 (Score Min 1, Max 5). Average Global Health percentage 66.25%. Average ICIQ score = 3.375 (Min 0, Max 21).
Conclusion: Overall, complications following Augmentation Cystoplasty were in keeping with other centres, based on current literature. Patients largely expressed a good QoL, with minimal post-procedure incontinence reported.